The Depressive Phase of Manic-Depressive Insanity

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Introductory.

It is to the genius of Kraepelin, whose death in 1926 must have spared him the pain of encountering Nazism, that we owe both the title and our present conception of manic-depressive insanity. This conception embraces far more than the clinical close relationship which sometimes exists between states of mania and states of melancholia. A good deal, in fact, was known about this relationship before Kraepelin's time, and its importance has, I believe, been considerably overstressed. A small percentage of patients undoubtedly exhibit in their lifetime attacks of both mania and melancholia. A still smaller percentage exhibit alternating cycles of the two conditions with few or no remissions. A mild elation is not infrequently observed at the termination of a melancholic attack, and transitory periods of depression may occasionally be observed during the course of an attack of mania. When all this is said, however, the fact remains that in the great bulk of cases no such relationship is evident, and the diseases progress with utterly dissimilar symptoms along entirely different courses. On symptomatology alone, therefore, there would, I fear, be little justification for the conception embodied in the term "manic-depressive." Kraepelin, however, probed more deeply into the problem, and his great contribution, and, in my opinion, justification for his conception, lay in his elucidation of what he termed the "fundamental states" common to both conditions. Although we can to-day, in the light of much fine work done on the psychology of the child, considerably amplify Kraepelin's viewpoint of the abnormalities of temperament which he terms "fundamental states," yet his description[1] of these four states which he calls the "depressive temperament," the "manic temperament," the "irritable temperament," and the "cyclothymic temperament," must remain a classic in the literature of psychological medicine.

In the paper which follows I propose to limit myself to a consideration of the purely clinical aspects of the depressive phase of manic-depressive insanity, or, as it is more commonly known, melancholia.

Melancholia.

Melancholia holds an almost unique position amongst diseases in that it is characterized by only one essential symptom—mental or emotional depression. The fact, however, that there is only one symptom essential to diagnosis often makes the latter a very difficult problem. Two crucial questions present themselves; firstly, whether depression is or is not present, and, secondly, whether such depression is of such a character as to justify a diagnosis of melancholia. An attempt will be made to answer both these questions in the course of the consideration of the symptomatology of the condition, and, to facilitate this, I

will consider three degrees of severity, cases of mild degree, those of moderate severity, and those of severe degree.

Cases of Mild Degree.

Cases of melancholia of mild degree are more often seen, in the first place, by general practitioners or by specialists in other branches of medicine than by mental specialists. These cases are probably amongst the most anxious with which any physician can be called upon to deal. Although the symptoms complained of may vary to an astonishing extent, an immediate and exact diagnosis is imperative, and, following the diagnosis, the physician must face the even more difficult task of deciding upon the correct line of treatment.

Patients suffering from a mild degree of melancholia may be divided into three classes; (a) those who appreciate the fact that they are mentally depressed and are willing to acknowledge it; (b) those who suspect that mental depression is at the root of their trouble but wish to conceal this fact; (c) those who are genuinely unconscious that mental factors have anything to do with their feelings of ill health.

(a) Diagnosis in this class is not, as a rule, difficult. There are, however, several pitfalls which should be avoided. It is scarcely necessary to point out that the mere statement from a patient that he is suffering from mental depression is insufficient to warrant a diagnosis, although care should be taken before such a diagnosis is set aside. The subject will be gone into more fully at a later stage, but here I would just remark that some patients, with perhaps a slightly hysterical "make up," seize upon the term "mental depression" in much the same way as they more frequently make use of "paralysis" or "heart disease." Again, the depression complained of may be simply a feeling of not being in robust health such as the early sufferer from tuberculosis, the anæmias, malignant disease, etc., may experience. In my opinion, however, in the past too much emphasis has been laid upon the possibility of overlooking a physical cause. In practice one rarely has any doubts as to the rôle of a physical cause after the usual physical examination, while if a decision is deferred, as may be requested by the relations, until more detailed examinations are carried out, vital time may be lost and unwarrantable risks incurred. Even in the presence of a definite physical cause, e.g., high blood-pressure, gynæcological abnormalities, conditions of sepsis, etc., the assumption, so often made, that the mental state is dependent upon these is fraught with much fallacy and danger.

Likewise the revelation by the patient that he has recently experienced some acute form of stress, e.g., financial or domestic calamity, must not tempt the physician to assume that he is dealing with a mere aftermath of such calamity which presumably may be regarded as temporary. The essential fact in melancholia of any degree is to establish its presence. The question of cause, physcial or mental, is, at the outset, a very secondary matter.

(b) A considerable number of sufferers from early melancholia will come under the second category, that is, they appreciate that a changed mental state has a

great deal to do with their feeling of ill-health, but are unwilling, for many reasons, to acknowledge this. The main reason is probably the fear that such a disclosure will lead to a diagnosis of a mental illness or of "insanity." These patients therefore usually complain of a variety of physical symptoms, e.g., headache, insomnia, various derangements of digestion, menstrual troubles, high blood-pressure, etc. In point of fact the physical symptoms complained of are in the majority of cases well founded. While melancholia of any degree may exist without the slightest evidence of any physical derangement, in a large percentage of cases it produces some or all of the above symptoms. Sleep is almost always considerably disturbed in the early stages of the disease. The patients usually complain either of inability to get off to sleep or of waking very early. Disturbing dreams and nightmares are frequent. The digestive system is also frequently upset. Appetite is poor and capricious, the tongue furred and constipation almost constant. As a consequence loss of weight almost invariably follows, but, of course, as an early symptom this can rarely be of value.

Some disturbance of the menstrual function is frequently met with, the commonest, in my experience, being amenorrhœa, especially in girls and young unmarried women. A number of these patients had been subjected to varying treatments, including the insertion of huge pessaries for supposed malposition of the uterus.

Headache is often complained of, but by "headache" these patients usually mean that dull oppressive feeling which is in reality mental depression. A true sharp persistent headache is in fact quite a rarity in mental disease, and if present should seriously suggest a revision of the diagnosis.

From the foregoing it will be clear that a diagnosis in these cases can only be arrived at by an appreciation of the emotional condition of the patient. Although the patient may actually deny being depressed, that suggestion of increased mental tension which depression causes is unmistakeable to the practised observer. It is essential to bear in mind that these patients will talk freely and connectedly and have a full grasp of all their business and social relationships. There will be no obvious delusion, no mental confusion, no loss of memory. In a long conversation, however, the increased mental tension referred to is rarely absent. One misses the normal, spontaneous, fleeting changes of expression, and the most thorough physical examination somehow fails to give the expected relief.

(c) Patients who are completely unconscious of the fact that a depressed state is at the root of their trouble may deceive the physician by their obvious sincerity. Such patients have often made up their minds that some physical abnormality is the main source of all their trouble, and they frequently merely consult their doctor in order to be recommended to a specialist in some particular field. The latter has almost perforce to carry out a detailed examination, and the finding of some slight abnormality only completes the confusion. The tragedy of many of these cases is that so much vital time is lost that a suicidal attempt is made before anyone realises that the trouble is basically mental.

Melancholia of Moderate Severity.

In melancholia of moderate severity the diagnosis is usually obvious unless in fact the patient fears being sent to a mental hospital and makes an effort to conceal his symptoms. In melancholia of this degree the patient, as a rule, finds it much more difficult to conceal his emotional depression, and the latter has frequently so warped his judgment that depressive ideas—amounting in many cases to delusions—are given expression to. The patient, for example, fears he has cancer or heart disease, believes all his investments will fail, thinks his children will become mentally affected, ascribes all his symptoms to some youthful indiscretion for which he states he can never be forgiven, etc. It is essential, however, to bear in mind that depressive ideas are not necessarily elicited in any stage of melancholia and that their absence should never, in itself, weigh against a diagnosis being made.

Melancholia of Severe Degree.

Whereas cases of mild degree of melancholia pass imperceptibly into those of moderate degree, the latter also pass imperceptibly into those of severe degree. In the latter condition restlessness is often a prominent feature. The patient paces up and down the room, refuses to stay in bed, rubs his hands, picks at his skin, gives vent to moaning sounds. Delusions, when elicited, are usually strongly marked and are not, as is so common in the other two varieties, merely pessimistic exaggerations, but are frank delusions of calamity or unworthiness. The patient, for example, often states that something dreadful is going to happen, that his children have all been killed, that he has lost all his money, that his bowels are completely stopped. At the same time he frequently appears to be in a condition of acute fear or dread, with anxious or frightened expression and rapid pulse. Delusions of unworthiness, e.g., that he has committed some unpardonable sin, may be present, but are more frequently encountered at a much later stage. The same remark applies to two other signs so beloved of the textbooks—the furrowed brow and slow stooping gait.

In a certain percentage of cases the acute attack appears to rob the patient of all volition and he either answers in monosyllables or refuses to speak altogether. It is essential to bear in mind that melancholia in this guise is always of the acute variety, and that a patient who has remained immobile and mute for days or weeks, may make, when the opportunity arises, a determined and well-planned attempt at suicide.

Differential Diagnosis.

A number of mental conditions may superficially resemble melancholia. An immediate precise diagnosis is, of course, only essential in the milder forms of the disease—the type of case which one may see in the consulting-room. In acute psychotic conditions, where the obvious course is certification or the placing under continuous nursing supervision, an immediate exact diagnosis is neither called for nor always perhaps possible.

Dementia præcox sometimes begins with a depressed phase, but apathy or

indifference is much more characteristic of the emotional picture than real depression. A history of eccentric behaviour, bizarre acts, sullen moods, impulsive or violent outbursts, will go far to strengthen the suspicion of a primary dementia. A point that is often immediately helpful is that melancholic patients are usually described by their relations as being most conscientious and reliable before their illness—often the mainstay of the home or business—whereas in the case of dementia præcox the early history is rarely satisfactory, and the subject is described as being unreliable, morose, sullen, given to moods, or at best a solitary, hypersensitive individual. It is well also to bear in mind that melancholia is not at all infrequently encountered in the adolescent period—from 15 years upwards.

There are some conditions, often called anxiety states or anxiety neuroses, which are not fundamentally different from an early stage of melancholia. Where a degree of more or less permanent emotional depression is present one is driven to adopt the graver diagnosis.

Functional cases with a large element of hysteria may on occasions superficially resemble melancholia. Speaking generally, however, it will usually be found that where the hysterical element is at all prominent the illness is a source of interest to the patient, who often becomes quite animated in disclosing the various symptoms. The suggestion of real suffering, so characteristic of melancholia, is absent. In exceptional, but not so very infrequent cases, the two conditions co-exist.

Confusional states usually develop with some abruptness. In a fair percentage of these cases a predisposing cause can be found, e.g., alcohol, drugs, febrile toxæmia. If the case is seen before confusion has become marked the resemblance to melancholia may be striking, but on close examination the patient is found to be more dull and listless rather than depressed, and to be unable to give a really coherent or complete account of himself.

Depressive delusional or paranoid states may be indistinguishable from melancholia even after months of observation. The condition, however, is a comparatively rare one.

In middle-aged men the possibility of a depressed form of general paralysis must, of course, always be kept in mind. A routine Wassermann is the only way to avoid a mistake, as the physical symptoms may not be at all distinctive, and in any case are particularly difficult to estimate in non-co-operative patients.

In middle-aged subjects also the possibility of a cerebral tumour should not be entirely dismissed. Apart from focal signs or changes in the fundus, an organic origin of a mental condition is strongly suggested by symptoms pointing to a "reduction" of the personality, e.g., the carrying out of any unusual or bizarre action, neglect of routine duties, amnesic episodes, etc.

In patients from 55 years of age upwards, and in exceptional cases below this age, the illness is frequently associated with a grave degree of arterio-sclerosis, with or without kidney involvement. In many of these cases the illness proceeds inevitably to a fatal termination in from a few months to one or two years. The physical symptoms at first are never alarming, but later increasing weakness draws

attention to the cardio-vascular degeneration. The mental condition, as a rule, remains intractable to the end.

Course and Prognosis.

Recovery from melancholia of even mild degree is exceptional under two to three months. The importance of the "time factor" in the recovery from mental illness is well exemplified in this disease, where it would almost seem that irrespective of any treatment that has yet been devised a minimum time limit for recovery is fixed. An appreciation of this is of more than academic importance and its bearing on treatment is obvious. It will prevent, for example, undue pessimism on the part of either doctor or relations in the early stages of the illness, and what is perhaps equally important, will prevent an unfortunate patient from being subjected to a series of ever-changing treatments. While recovery may normally be expected to take place somewhere between the third and the seventh month, a not inconsiderable percentage will make complete recoveries before the end of the second year's illness, and in exceptional cases recovery may be delayed as long as five or seven years, or longer. In fact as long as a case of melancholia remains apparently uncomplicated the hope of recovery can never be abandoned.

Apart from the question of the duration of the illness the probability of ultimate recovery must be considered. In a straightforward case—where the diagnosis is not in question—where the bodily health is satisfactory, and where immediate provision can be made for suitable environment and treatment, this must be regarded as very favourable, so favourable that one is usually justified in giving a hopeful prognosis from the outset. It will, of course, be appreciated from the foregoing that, as a rule, a much more guarded prognosis must be given in patients over 55 years of age.

The possibility of a second attack in the near or remote future is a question which is very often raised by the relations. Curiously enough, this question is usually asked in the early stages when there is as yet no sign of recovery from the immediate attack. Only rarely is it repeated when the patient has regained full health and vigour. That some patients have more than one attack of melancholia is, of course, a commonplace to any psychiatrist. In a considerable experience, however, of this disease I am satisfied that the percentage of patients in whom a relapse ultimately takes place is not very large. Also one must take into account the undoubted fact that many patients emerge from this illness with a much fuller understanding of themselves, and with, therefore, mathematically speaking, a smaller probability of developing a mental illness than at any time in their lives. Their personalities have, so to speak, become more strongly integrated.

In considering the future of a patient who has made a complete recovery from an attack of melancholia, it may happen on rare occasions that grave questions will be put to the physician, such as, for example, the desirability of marriage, children, occupations, etc. While I realise that other views have been expressed, it has always been my personal practice, which I have so far not regretted, never

to place any obstruction in the way of these patients to their leading a normal, full life. Such a life is unquestionably, from the psychological point of view, the healthiest, and the best guarantee against future trouble, whilst a restriction, perhaps lightly imposed on a doubtful scientific basis, may prove a handicap against which the strongest will struggle in vain.

Treatment. General Considerations.

When faced with an undoubted case of melancholia, whether of mild or more marked degree, the first question which demands an immediate answer is—what reserve of volitional control has the patient got, or, in plainer language, what is the risk of a suicidal attempt?

In acute cases one assumes, whether or not the patient gives expression to suicidal ideas, that there is no reserve, and one takes the necessary steps to have the patient under continuous nursing supervision night and day. In well marked though less acute cases one will again usually endeavour to play for safety, and this type of case can frequently be persuaded, often with excellent results, to enter a mental hospital as a voluntary patient. It is in the comparatively mild type of case, where perhaps the patient is carrying on fairly competently with his work, in which the greatest difficulty arises.

In trying to arrive at a decision in these cases one takes into account a number of factors, but in the end the decision is probably arrived at by a kind of intuition. The older psychiatrists used to place great importance upon what they called the degree of "insight" into the illness, by which they meant how far the patient understood his illness. In the cases we are now considering this will not be of much help, as these patients will be able to discuss their illnesses quite rationally and will not give expression to any delusion. The apparent intensity or "depth" of the depression is, of course, always taken into account, but must be interpreted cautiously, as there is often considerable variation in the degree of depression and one may be interviewing the patient in one of his better periods. The most helpful consideration is probably the general demeanour of the patient taken in conjunction with his replies to certain questions. One asks, for example, "What do you feel like in your worst moments?" "How bad is the worst depression you have experienced?" etc. If the patient admits of suicidal thoughts at such times one can further enquire what degree of control he felt he had over such thoughts. If the patient will make no reference to suicide, it is often, though perhaps not always, advisable to put the matter bluntly and to ask whether suicidal thoughts ever entered his mind, and, if so, how far he dwelt upon them. One should, of course, immediately emphasise to the patient that such thoughts and ideas are the invariable accompaniment of all depressed states, that in themselves they signify nothing, and that their early disappearance may be confidently anticipated.

If, after examination, one can decide that volitional control seems adequate, and that the patient may safely be treated as an out-patient, it is then usually wise to insist on seeing him at least twice weekly. In this way one will note any trend

for the better or worse and take action accordingly. There is, in my opinion, no certain means of knowing whether an apparently mild attack will remain as such or will eventually and inevitably, despite any treatment, deepen into an attack of severe degree. Such patients, therefore, must be taken in hand firmly and must remain under the very definite control of their doctor, so that changes of air and sea voyages are ruled out.

Psychological Treatment of Melancholia.

The psychological treatment of melancholia is to some extent influenced by the degree of severity of the case with which one is dealing. In all types of case, however, I would strongly advise against any attempt at mental probing, or so-called "analysis." The physician, in fact, must be constantly on his guard not to allow the patient to make unnecessary disclosures of the intimate details of his life. The self-depreciatory attitude which mental depression evokes in the majority of patients convinces them that they are "failures," and consequently they search painstakingly in the past for some act of commission or omission which will account for such failure. Hence in order to be relieved of the intolerable burden of depression they will reveal, if allowed, every intimate detail of their lives, a procedure which is as unhealthy, psychologically, in the mentally affected as it is in the most normal. It is in all cases quite sufficient to allow the patient unhurriedly to explain his major worries and anxieties. Following this it is essential immediately to impress upon the patient that he is suffering from one of the commonest of all forms of nervous trouble, that it has no connection whatever with any real or imaginary delinquency in the past, and that with patience and his co-operation he may look forward to a complete recovery from all his symptoms. It will be necessary, in fact, to repeat these assurances, in varied form, very frequently throughout the illness.

Treatment of Melancholia of Moderate or Severe Degree.

Melancholia of this degree is almost of necessity treated in a mental hospital, public or private. In practice one usually finds innumerable objections to this course put forward by the relations, and sometimes, unfortunately, it is not possible to overcome these until the unsatisfactory progress of the patient adds convincing argument. Many people sincerely view with great anxiety the association of their relation with other mental patients, think that such association will exert a profound psychic shock, and believe that if recovery should take place the memory of such an experience will never fade. I can only state that from a considerable experience of both public and private mental hospitals I have found such fears to be almost entirely groundless. It has to be kept in mind that a well-administered mental hospital is a highly complex organization solely adapted for the care and treatment of mental illness. Not only are suitable buildings and grounds required, both of which have evolved from years of patient study, but the building up of an experienced and capable nursing staff is a matter which will take, with reasonable good luck, anything from ten to twenty years. No one but those in daily contact with mental illness can appreciate the wealth of knowledge a capable mental nurse

can bring to the assistance of both patient and doctor. It is by means of this knowledge, only acquired by years of enthusiasm for the art and some sacrifice, that the restless, agitated patient is made to feel at home, that the sleepless patient finds he can obtain sleep, and that the patient resigned to apathy and despair finds his interest in the outside world reawakening.

Following admission to a mental hospital a preliminary rest in bed is most important. The actual duration of such rest must be assessed individually in each case, but should rarely be shorter than two weeks. Patients exhibiting considerable exhaustion or very acute depression or restlessness will usually benefit from much longer periods. During this period the patient gets an opportunity to become familiar with his strange surroundings, is usually able to build up to some extent physically, and the psychological effect of confinement in bed does something to convince him that he is the victim of an illness and not of some mysterious visitation like "insanity."

It is scarcely necessary to state that at this time and usually until complete recovery takes place the patient must be under continuous nursing observation both by night and by day. This is often ideally accomplished in an open dormitory where the patient can be under continuous observation without anything to draw attention to this. The presence of other patients, instead of acting as a shock, soon provides interest and variety, and, in my experience, is a decided aid to sleep.

The most generally useful drug in melancholia, particularly in restless or sleepless patients, is bromide of ammonia. This is usually prescribed in from ten- to fifteen-grain doses three times daily, and it can often be usefully combined with one of the citrates of iron. If this is found insufficient to produce a fair night's rest an occasional potent hypnotic should be given. Generally speaking, however, with skilled nursing the question of sleep soon ceases to be a problem, and it is always unwise to appear too directly concerned with it before the patient.

Following what appears an adequate period of rest in bed the patient is allowed to move about in association with other patients. Here I would emphasize the importance of not rushing matters too quickly. Much as I appreciate the value of occupational therapy, it must be kept in mind that a recently depressed patient is not a fit subject for concentrating upon various tasks and crafts. At the same time solitary brooding by himself should not be encouraged. It is here that the ingenuity and art of the good mental nurse will find full scope in devising, and not too obviously, simple tasks, hobbies, and interests. The milder indoor and outdoor recreations, e.g., croquet, clock golf, billiards, bagatelle, etc., are also very useful, while short country walks, simple exercises in the open air, car drives, etc., fill up the remainder of the day.

Most important perhaps of all, the psychological atmosphere must be one of ease and optimism, and hence there must be no suggestion of compulsion, dragooning, or the meticulous complying with exacting rules and regulations. The same remarks could be equally applied to the staff. Where there is carping criticism from higher officials, pin-pricking or mistaken over-zealousness, the

resulting tension and lack of spontaneity creates an atmosphere in which recovery cannot be hoped for.

Treatment in Convalescent Melancholia.

Melancholia in its various stages of recovery may present some difficult problems. As soon as the initial acute stage of depression has been overcome the patient frequently asserts that he is now completely recovered and asks to be discharged or granted certain liberties and privileges. The obvious improvement in the patient's condition, coupled with the sometimes striking change in his demeanour, may lead the unwary and occasionally the most experienced to the conclusion that recovery is now complete. The patient's attitude is now often positive and impatient, but betrays a background of irritability and restlessness. The problem even when fully recognized cannot of course be solved by a simple blank refusal of the patient's requests. Such an action would only arouse antagonism and would indefinitely postpone further progress. I have found that most mental patients appreciate the argument that they have been through a serious illness, that a nervous breakdown is a much more serious matter than most bodily illnesses, and that therefore it is essential to make sure that their recovery is fully consolidated before taking risks of further strain. In addition, one can usually grant small concessions which involve no nursing risk, but which are sufficient to reassure the patient that his improved state is having adequate recognition.

When recovery is actually complete, this restless, irritable stage disappears, and by contrast the patient now co-operates cheerfully and willingly and is at pains not to make undue demands. Recovery in melancholia when once begun is often comparatively rapid, so that in a few weeks a noticeably depressed patient may display all the signs of complete recovery. These are—a uniformly cheerful and contented demeanour with no sign of depression at any time in the twenty-four hours, full natural sleep every night, natural and spontaneous interest in all his surroundings, disappearance of all tension in manner and speech, good appetite, and, in most cases, an increase in the body weight. When this stage has been reached the question of discharge must then be faced. Here I would strike a note of warning against timorous procrastination. The psychiatrist must have the courage of his convictions, and failure to recognise true recovery may have as disastrous consequences as failure to recognize symptoms of non-recovery. A rule I have often found useful when recovery is complete is to fix a date of discharge two or three weeks hence. The fixing of the date removes all anxiety from the patient, while it gives a further short period in which to make certain that the recovery will be maintained.

Physical Treatment in Melancholia.

In spite of much patient research work it has to be admitted that the physical treatment of mental illness does not yet rest on any sure basis. In melancholia the only physical abnormality I was ever able to detect with any degree of consistency was a fairly marked degree of secondary anæmia. In some cases this had progressed to a stage where a diagnosis of pernicious anæmia had to be excluded.

The correction of this anæmia is, of course, an important part of treatment, as are also, in most cases, measures calculated to increase the body weight. Having said this, however, I would strike a note of warning against undue activity in other forms of physical treatment. Focal sepsis, for example, can usually be found somewhere in every mental patient, as in most sane people, and yet I am convinced that to subject a mentally ill patient to dental and sinus procedures, colon lavage, vaccine therapy, etc., often does irreparable harm and rarely results in any benefit. The same remark can usually be applied to the various forms of electro-therapy, ultra violet radiation, etc. The proper place for such procedures is in the definitely convalescent patient who can co-operate willingly and cheerfully with what is being done, but even here great care has to be exercised, and unless the patient appears enthusiastic it is best to leave well enough alone. On more than one occasion I have had the mortification of seeing a promising recovery completely interrupted by such over-activity.

Middle-aged and elderly patients who are found to exhibit cardio-vascular degeneration, in varying degrees, with or without a raised blood-pressure, are often, I think, considerably benefited from rather prolonged periods of rest in bed.

The newer methods of treatment by insulin shock and convulsant drugs must, I think, still be regarded as *sub judice*. In any case they would scarcely be immediately applicable to a disease which, if properly handled, gives as gratifying a response to treatment as almost any major illness to which flesh is heir.

(1) "Manic-Depressive Insanity and Paranoia." Translated by R. Mary Barclay.

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